

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010314

STATE FILE NUMBER

FILED MAR 25 1959

Registration District No. 255 Primary Registration District No. 5873 Registrar's No. 12

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>OREGON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>OREGON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JOHNSON Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Johnson Township</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>M.</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/1898</u>	9. AGE (In years last birthday) <u>61</u>	10. UNDER 1 YEAR Months <u>1</u> Days <u>5</u>	11. UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>PARAGOULD, ARK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MILDRED W. WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES 1917-1917</u>		16. SOCIAL SECURITY NO. <u>532-28-3162</u>		17. INFORMANT <u>MRS. WILLIAMS</u> Address <u>OREGON COUNTY, MO</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Essential Hypertension</u>	
	DUE TO (c) <u>Senile body changes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u>		
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Alton Oregon Mo.</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Alton Oregon MO.</u>	
21. I attended the deceased from <u>6-24-56</u> to <u>3-17-59</u> and last seen <u>alive</u> on <u>3-14-59</u> Death occurred at <u>6:30 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. W. M. Cohen D.O. 2</u>				22b. ADDRESS <u>Alton, Mo.</u>	
				22c. DATE SIGNED <u>3-19-59.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3/19/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SMITH CEMETARY</u>		23d. LOCATION (City, town, or county) (State) <u>ALTON MO.</u>	
--	--	-------------------------------	--	---	--	---	--

24. FUNERAL DIRECTOR <u>John &amp; Clay Alton</u>		ADDRESS <u></u>		25. DATE RECD. BY LOCAL REG. <u>3/20-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs W C Johnson</u>	
--	--	--------------------	--	--	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 27 1959

AUG 19 1959

STATEMENT BY LICENSED EMBALMER

APR 19 1959

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *John D. Clary*.....  
Licensed Embalmer No. *4475*.....

P. O. Address *Box 398 alt*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.